Montgomery County Retiree Select Benefit Enrollment Form for 2004

PLEASE DO NOT STAPLE OR FOLD THIS FORM

MARKING INSTRUCTIONS

- **Use a No. 2 pencil only.**
- **Do not use ink, ballpoint, or felt tip pens.**
- **Make solid marks that fill the response completely.**
- **Erase cleanly any marks you wish to change.**
- **Make no stray marks on this form.**

CORRECT: ● **INCORRECT:** ✓ ✗ ⊖ ◔

STATUS

- ○ Retiree
- ○ Survivor
- ○ Divorcee

Your Social Security No.

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

Name:
Address:

Part A PERSONAL DATA

CURRENT COVERAGE:

Medical:

Dental:

Discount Vision:

Dependent Life:

Cost-Sharing %:

Expiration Date for County Cost-Sharing:

Part B ELIGIBLE DEPENDENTS:

(All dependents listed will be covered for any benefits options for which family coverage is elected; if more than one dependent is listed, the spouse/domestic partner will be covered for any benefit options for which employee plus one coverage is elected).

	Dependent's Name	Date of Birth	Gender	Relationship	Social Security #
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Add or delete dependents on separate form.

Part C MEDICAL PLAN

Retiree must select Primary Care Physician (PCP) directly with Plan.

(Choose one plan)

- ◯ Kaiser-Permanente
- ◯ Optimum Choice (requires enrollment form for PCP)
- ◯ CareFirst BCBS POS Plan (requires enrollment form for PCP)
- ◯ CareFirst BCBS POS Out of Area (for eligible participants only)
- ◯ No Medical Coverage **(I understand that if I do not elect coverage I will need to be covered under another plan. I also understand that I will not be able to re-elect the Indemnity Plan at a later date.)**

(Choose one coverage level)

- ◯ Single
- ◯ Employee plus one
- ◯ Family

Part D DENTAL PLAN

(Choose one)

- ◯ CIGNA Dental PPO (Traditional Dental Plan)
- ◯ No Dental Coverage (If no dental coverage was elected, there is a two year waiting period for re-entry.)

(Choose one coverage level)

- ◯ Single
- ◯ Employee plus one
- ◯ Family

Part E VISION PLAN

(Choose one)

- ◯ NVA Discount Vision Plan
- ◯ No Coverage

(Choose one coverage level)

- ◯ Single
- ◯ Employee plus one
- ◯ Family

Part F DEPENDENT LIFE (Choose one)

- ◯ $2,000-Spouse, $1,000-Child over 6 months, $100-Child under 6 months
- ◯ $4,000-Spouse, $2,000-Child over 6 months, $100-Child under 6 months
- ◯ $10,000-Spouse, $5,000-Child over 6 months, $100-Child under 6 months
- ◯ No Dependent Life Coverage

Part G SIGNATURE (Must be signed for elections to become effective)

I have read the enclosed enrollment materials, as well as the information available on the individual benefit plans. This enrollment form indicates my benefit elections for calendar year 2004. I understand that I am responsible for my share of the cost associated with these benefit elections. If I have elected no medical coverage, I certify that I have medical coverage through some other means. I understand that these elections are in effect for the entire 2004 calendar year and can only be changed during the year if I have a *Change in Status* (such as marriage, divorce, birth or adoption of a child). I also understand that I must notify the County within 60 days of such an event in order to make the necessary changes to my benefit elections. I authorize the release of information contained on this enrollment form to entities such as benefit providers, to the extent needed to properly administer the benefits I have elected.

I understand that enrollment in benefits to which I or my dependents are not entitled is considered fraud. In all cases, I am responsible for the accuracy of my benefit elections and coverage levels. I further understand that if I willfully misrepresent the eligibility of myself or my dependents on my enrollment forms, or fail to take the necessary action to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be canceled, I may be required to repay any claims which have been paid inappropriately, and I may face charges.

I understand that the County expects to continue the group insurance benefits, but it is the County's position that there is no implied contract between retired employees and the County to do so. I also understand that the County reserves the right at any time and for any lawful reason to amend its group insurance benefits for retired employees. Further, I understand that the group insurance benefits may also be amended by the County at any time, either prospectively or retroactively, to comply with the Internal Revenue Code.

Your Signature: _____ Date: _____

All forms must be signed and received in the Office of Human Resources, EOB 7th Floor, 101 Monroe Street, Rockville, MD 20850, no later than **5:00 p.m., Wednesday, November 12, 2003.**

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